

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name:</b> Women's Way	<b>CHAPTER 98</b>
<b>Address:</b> 845 22 <sup>nd</sup> Avenue Honolulu, Hawaii 96816	<b>Inspection Date:</b> March 25, 2019 Annual

**THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.**

**YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-98-11 Minimum standards for licensure; personnel. (e) There shall be documented evidence that every employee has a pre-employment and an annual health evaluation by a physician. These evaluations shall be specifically oriented to determine the presence of any infectious disease liable to harm a resident. Each health evaluation shall include a tuberculin skin test or a chest x-ray.</p> <p><b><u>FINDINGS</u></b> Employee #2 – No documented evidence of annual tuberculosis clearance.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;">ANNUAL TB CLEARANCE WAS COMPLETED ON 4/10/19. DOCUMENTATION PLACED IN EMPLOYEE #2 FILE.</p>	<p style="text-align: center;">4/10/19</p>

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<input checked="" type="checkbox"/>	<p>§11-98-11 <u>Minimum standards for licensure; personnel.</u> (e)            There shall be documented evidence that every employee has a pre-employment and an annual health evaluation by a physician. These evaluations shall be specifically oriented to determine the presence of any infectious disease liable to harm a resident. Each health evaluation shall include a tuberculin skin test or a chest x-ray.</p> <p><b>FINDINGS</b>            Employee #2 – No documented evidence of annual tuberculosis clearance.</p>	<p align="center"><b>PART 2</b></p> <p align="center"><b><u>FUTURE PLAN</u></b></p> <p align="center"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>THE DIRECTOR OF ADMINISTRATIVE SERVICES            AND ADMINISTRATIVE SECRETARY TO ALERT            STAFF 3 MONTHS PRIOR TO COMPLETE            ANNUAL TB CLEARANCE.</p> <p>NOTICES TO BE SENT TO EMPLOYEE'S            SUPERVISOR AND HARD COPY NOTICE SENT            TO EMPLOYEE TO ENSURE TIMELY            COMPLETION.</p>	<p>4/15/19</p> <p>ANIMAU</p> <p align="right">19 APR 22 PM 12:01</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-98-12 <u>Minimum standards for licensure; services.</u> (5) Individual records shall be kept on each resident which contain the following:</p> <p>Documentation that a physician was consulted within five days of admission as well as for all significant illnesses and injuries;</p> <p><b>FINDINGS</b> Residents #2, #3, &amp; #4 – Physician was not consulted within five (5) days of admission.</p>	<p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	

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<input checked="" type="checkbox"/>	<p>§11-98-12 <u>Minimum standards for licensure; services.</u> (5) Individual records shall be kept on each resident which contain the following:</p> <p>Documentation that a physician was consulted within five days of admission as well as for all significant illnesses and injuries;</p> <p><b><u>FINDINGS</u></b> Residents #2, #3, &amp; #4 – Physician was not consulted within five (5) days of admission.</p>	<p>PART 2</p> <p><b><u>FUTURE PLAN</u></b></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>"ACKNOWLEDGEMENT OF FTS ADMISSION" FORM WAS CREATED TO ALERT CLIENT'S PHYSICIAN OF CLIENT'S ADMISSION TO THE PROGRAM.</p> <p>THE AGENCY NURSE TO SEND THE FORM TO PHYSICIAN ON THE DAY OF ADMISSION</p>	<p>4/15/19</p> <p>AT ADMISSION</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-98-14 <u>Physical facility.</u> (c) Maintenance. Facilities shall be maintained in accordance with provisions of state and county zoning, building, fire, safety and health codes in the State.</p> <p><b><u>FINDINGS</u></b> Cottage #2 Room 15 – Light bulb not working.</p> <p>Cottage #3 Room 5 – Light bulb not working.</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>REPLACED LIGHT BULB IN COTTAGE #2 Room 15 on 4/15/19</p> <p>REPLACED LIGHT BULB IN COTTAGE #3 Room 5 on 4/15/19</p>	<p>4/15/19</p> <p>4/15/19</p>

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☒	<p>§11-98-14 <u>Physical facility.</u> (c) Maintenance. Facilities shall be maintained in accordance with provisions of state and county zoning, building, fire, safety and health codes in the State.</p> <p><b><u>FINDINGS</u></b> Cottage #2 Room 15 – Light bulb not working.  Cottage #3 Room 5 – Light bulb not working.</p>	<p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>WHEN LIGHT BULB IS OUT, SUPPORT STAFF TO COMPLETE A MAINTENANCE WORK ORDER AND SUBMIT TO MAINTENANCE SUPERVISOR FOR REPAIR.</p> <p>DEPARTMENT STAFF TO COMPLETE A FACILITY/BUILDING INSPECTION EVERY MONTH TO IDENTIFY AND REPAIR ANY ITEMS THAT ARE NOT UP TO THE STATE SAFETY AND HEALTH CODES.</p>	<p>IMMEDIATELY OR WITHIN 24 HOURS</p> <p>MONTHLY</p>

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Licensee's/Administrator's Signature: Ry Ugi

Print Name: Ry Ugi

Date: 4/18/19

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